Caso clinico

The Emergency Department's management of a severe acute psychomotor agitation: a rare case of an adult presentation of Rasmussen's Syndrome?

La gestione in Pronto Soccorso di una grave agitazione psicomotoria acuta: un raro caso di presentazione adulta della Sindrome di Rasmussen?

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SUMMARY. We report a severe acute psychomotor agitation treated in the Emergency Department. We hypothesized to be a rare case of an adult presentation of Rasmussen's Syndrome.

KEY WORDS: psychomotor agitation, violence/aggression, Rasmussen's syndrome.

RIASSUNTO. Segnaliamo una grave agitazione psicomotoria acuta trattata in Pronto Soccorso. Abbiamo ipotizzato che fosse un raro caso di presentazione adulta della sindrome di Rasmussen.

PAROLE CHIAVE: agitazione psicomotoria, violenza/aggressività, sindrome di Rasmussen.

The rising agitated patient population accessing the emergency department (ED) has caused increasing safety threats and difficulty to manage for health care workers and patients[1].

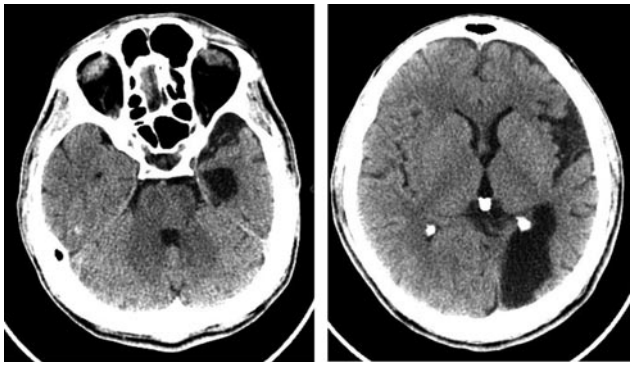
Psychomotor agitation is a state of motor restlessness and mental tension that requires prompt recognition and differential diagnosis either related to a medical condition, or substance-use intoxication/withdrawal disorder, or psychiatric disorder[2].

Here we describe a clinical case of an adult man who came to the ED of a General Hospital with severe psychomotor agitation, as well as neurological focal signs, characterized by clonic jerks of the arm. He had a significant psychiatric history, but no significant neurologic history.

At the psychiatric evaluation, psychomotor agitation was characterized by extremely violent behavior, combative attitude, hyperreactivity to stimuli, irritability, inappropriate behavior without a clear purpose, restlessness, exaggerated gesticulation, facial tension, angry expression, raised tone of voice, an altered emotional state with a severe grade of anxiety, consciousness fluctuations, temporo-spatial disorientation, persecutory ideation, tachycardia, tachypnoea, sweating, and tremor. Neurological signs such as walking difficulty, difficulty in opponent movements, and pointing were also observed. After a long verbal inefficacious de-escalation, i.m. delorazepam 5 mg and promazine 50 mg were first administered to the patient, and then after about an hour, i.v. valproate 400 mg and lorazepam 4 mg in 100 cc F.S. were infused for tranquilization. Blood test and ECG were performed: results showed normal values, except for high blood ethanol concentrations (119 mg/dl). After about four hours, he became calm, collaborative, and willing to tell family medical and psychiatric history. The patient gave informed consent and his anonymity was preserved according to Hospital ethical protocol.

Psychiatric personal history was reported by the patient and a relative: his parents died in a car accident when he was 10 years old, then he was adopted. His mother suffered from a severe treatment-resistant grand mal seizure and the patient was traumatized by the mother's crises. He was described as a very anxious person with emotional lability, feeling of emptiness, suddenly bursting out with anger, impulsivity (alcohol-binging), unstable relationships, fears of being abandoned and lonely. Further, he reported that often at home, when "feeling strong emotions", he fell and lost consciousness for few seconds. He told that a few years before he already consulted a psychiatrist and he received a diagnosis of Borderline Personality Disorder (BPD), but he did not want to be treated.

Due to the observed motor incoordination, the patient underwent a neurological evaluation that showed a unilateral lack of coordination of the right arm movements, such as dysmetria.



A B

Figure 1. Axial CT scan showing left temporal (A) and occipital (B) horn dilatation associated with temporal CSF enlargement.

A CT brain scan (Figure 1) showed dilated left temporal horn, posterior horn of the left lateral ventricle with possible ex-vacuo ventricular dilatation origin. The patient was referred to neurological hospitalization but he refused the treatment plan.

A Rasmussen's encephalitis (RE) was hypothesized for this case. Rasmussen was first described as a progressive epileptic disorder in children, due to chronic unilateral encephalitis[3] . It is now well recognized that RE has also an adult-onset[4]. It is characterized by unilateral hemispheric atrophy, drug-resistant focal epilepsy, and progressive neurological deficits[5]. In some cases, severe violent behavior might be also related to brain alterations due to encephalitis[6].

Relating to the reported BPD diagnosis, we might rather suppose that the psychiatric symptoms described here are part of an epileptoid personality, which includes a pervasive pattern of instability of interpersonal relationships, self-image and affects, irritability, selfishness, marked impulsivity with explosive behavior[7].

These observations underline the challenge of evaluating psychomotor agitation in the ED when both neurological and psychiatric presentations are interrelated, considering the necessity for a prompt differential diagnosis and treatment, and the severe discomfort experienced by the patient. Of primary importance is the role of the liaison psychiatrist who cooperates with the ED healthcare team in the case management. The psychiatrist has to choose an adequate treatment strategy aiming at reducing the risks related to psychomotor agitation and allowing the patient to undergo the necessary instrumental diagnostic procedures.

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REFERENCES

1. New A, Tucci VT, Rios J. A Modern Day Fight Club? The Stabilization and Management of Acutely Agitated Patients in the Emergency Department. Psych Clin North Am 2017; 40: 397-410.
2. Vieta E, Garriga M, Cardete L,et al.. Protocol for the management of psychiatric patients with psychomotor agitation. BMC Psychiatry 2017; 17: 328.
3. Rasmussen T, Olszewski J, Lloydsmith D. Focal seizures due to chronic localized encephalitis. Neurology 1958; 8: 435-45.
4. Villani F, Pincherle A, Antozzi C, et al. Adult-onset Rasmussen's encephalitis: anatomical-electrographic-clinical features of 7 Italian cases. Epilepsia 2006; 47(Suppl 5): 41-6.
5. Casciato S, Di Bonaventura C, Fattouch J, et al. Extrarolandic electroclinical findings in the evolution of adult-onset Rasmussen's encephalitis. Epilepsy Behav 2013; 28: 467-73.
6. Restrepo-Martinez M, Ramirez-Bermudez J, Bayliss L, Espinola-Nadurille M.. Characterisation and outcome of neuropsychiatric symptoms in patients with anti-NMDAR encephalitis. Acta Neuropsychiatr 2020; 32: 92-8.
7. Tsopelas ND, Saintfort R, Fricchione GL. The relationship of psychiatric illnesses and seizures. Curr Psychiatry Rep 2001; 3: 235-42.